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### Partnership working and outcomes

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## **Partnership working and outcomes: do health and social care partnerships deliver for users and carers?**

### **Abstract**

Working in partnership, both across social care and health and with service users, has been a persistent theme of the health and social care modernisation agenda. Despite a relatively underdeveloped evidence base, the development of health and social care partnerships has continued to feature in recent policy and legislative initiatives in the UK. At the same time there has been a major shift in focus towards the outcomes that support services deliver. A central question remaining is whether the policy initiatives driving the development of health and social care partnerships are delivering improved outcomes, particularly the outcomes valued by people who use services. This paper outlines research designed to explore this issue across 15 health and social care partnerships in England and Scotland, building from previous research by the Social Policy Research Unit based at the University of York. It sought to assess the extent to which health and social care partnerships deliver the outcomes people who use services value, and to determine the features of partnership working associated with the delivery of these outcomes.

A robust outcomes framework was defined which provided the basis for interviews with those receiving support from partnerships. Working with three user-researcher organisations, interviews were completed with 230 individuals in 2006. On the basis of this, some service users were able to identify features of partnership that particularly contributed to improved outcomes. These included continuity of staff and sufficient staff

and a range of resources, including the availability of long-term and preventative services. Given the definitional and methodological complexity surrounding partnership working, and the challenges of attribution, the study faced some limitations in its ability to make wider inferences about partnership and outcomes. A theory of change should be employed in future studies of this type.

### **Key words**

EVIDENCE-BASED PRACTICE, HEALTH AND SOCIAL CARE, OUTCOME MEASUREMENT, USERS' VIEWS

### **What is known about this topic**

- Most research on partnership working has focused on process rather than on outcomes
- Outcomes important to people who use services can be categorised into three types: quality of life, process, and change

### **What this paper adds**

- The salience of the three categories of outcome identified by earlier research at the University of York was confirmed in interviews with people using health and social care services, with some amendments
- Individuals receiving support through well established health and social care partnerships broadly reported good outcomes
- Some service users identified features of partnership working which they associated with positive outcomes, namely: co-location, multidisciplinary teams, specialist partnership and extended partnership.

## **Introduction**

Partnership working between health and social care has been an enduring element of policy directives across jurisdictions throughout Europe and North America in recent years, in part a response to what Lewis (2001) has characterised for the UK as 'half a century of hidden policy conflict'. The focus accelerated with the local government modernisation agenda in the late nineties and was given renewed emphasis by the economic downturn (Harvey et al, 2011). A recent emphasis on outcomes has been a welcome development, with the expectation of a major shift towards outcome-focused design and delivery across health and social care. Across the countries of the UK a range of initiatives have sought to transform the traditional concern with inputs and outputs to an emphasis on impact as captured through outcomes. A key distinction is between outcomes at the individual or personal level (the focus of this paper) and service-based outcomes.

This article reports findings from a two year research project funded under a UK Department of Health initiative, Modernising Adult Social Care (MASC) (Newman and Hughes, 2007) that sought to explore the contribution that partnership working can make to outcomes for people using services. The paper considers the literature in relation to personal outcomes, before exploring partnership working in more detail.

## **Partnership working**

Exploration of partnership working can rapidly become mired in issues of definition. This article will follow a common convention which identifies partnership as the process of working together and integration as the outcome once agencies or activities have merged.

Within partnership working a continuum should be recognised, from tentative collaboration between specific individuals at one end of the spectrum, through formalised joint delivery, to combination into a single agency, full integration, at the other.

The arguments for partnership working include more coherent and effective service delivery, added value from individuals and agencies working together, enhanced understanding of different professional roles, creation of a shared culture and greater responsiveness to people using services, which in turn result in better outcomes for people using services (Petch, 2012). Throughout the nineties there was a growing emphasis across the UK on the perceived value of a co-ordinated approach to service specification and development. With the election of a new Westminster government in 1997, their declared intent was to demolish the 'Berlin Wall' between health and social care services (Hiscock and Pearson, 1999). This led in England to the 1999 Health Act which sought to advance partnership working through the creation of the Health Act flexibilities – pooled budgets, lead commissioning and integrated provision - designed to remove structural barriers.

### **Evidence for partnership working**

Despite the continued focus on partnership working, progress in establishing partnerships at a local level has been relatively slow. Moreover, some of the expectations associated with partnership working, including improved understandings of other working cultures and the creation of a new, shared culture (Sullivan and Skelcher, 2002) have not been particularly well evidenced to date (Cameron et al, 2000, Dowling et al, 2004; Petch, 2012). Although there has been an expectation that enhanced partnership working and structural integration

would be economically effective, a review commissioned by Scottish Government concluded in respect of financial integration that 'robust evidence for improved health outcomes or cost savings is lacking' (Weatherley et al, 2010).

Although early studies focusing on individual outcomes did not provide definitive evidence (Brown et al, 2003; Kharicha et al, 2004; Townsley et al, 2004; Davey et al, 2005, Hultberg, 2005), more recent studies, primarily from outwith the UK, have had more promising results (Ham et al, 2008; Glasby and Dickinson, 2009; Curry and Ham, 2010). In North America (Kodner, 2006) these have included the OnLok demonstration project which became PACE in the USA, the Quebec-based SIPA, and the Canadian PRISMA (Tourigny et al, 2004). High profile programmes in Europe (Leichsenring and Alaszewski, 2004; Billings and Leichsenring, 2005) have included CARMEN (Nies, 2006), PROCARE (Coxon, 2005), and the Vittorio Veneto and Rovereto projects in Italy (Bernabei et al, 1998). Evaluations of the OnLok, Vittorio Veneto and Rovereto initiatives all suggested that integrated working reduced the cumulative number of days older people stayed in institutional care.

Johri et al (2003) attempted an early synthesis of the evidence from international experiments in integrated care in the OECD countries. Focusing primarily on rates of institutionalisation, this suggested that common features of these projects were case management, geriatric assessment and a multi-disciplinary team; a single entry-point; and financial levers. It is important to note, however, that selecting bed use as the primary outcome provides only a partial account. As both Nies (2006) and Freeman and Peck (2006) have highlighted, outcomes need to be considered across three domains: quality of care,

quality of life, and system efficiency. Achievement of user-defined outcomes, moreover, should be critical in the judgement of the effectiveness of partnership working (Beresford and Branfield, 2006; Rummery, 2009).

There are significant challenges involved in researching the effectiveness of partnership. The studies cited here reflect both the 'methodological anarchy and definitional chaos' (Ling, 2000:82) which characterises the partnership agenda, and the challenges of evaluation in a real world environment where practice is constantly evolving and adapting as it seeks to implement policy (Peck et al, 2001; Dickinson, 2008). El Ansari et al (2001) provide a useful discussion of the complexities of establishing the evidence base for partnership working, including difficulty in capturing the diverse factors that impact on the effectiveness of collaboration and a need to focus on the specifics of 'what works for whom under what circumstances'. Decisions have to be made as to whether any evaluation is conducted at a macro or micro level and the appropriate timescale for measuring effects. A key challenge has been attribution. To what extent can it be assumed that the outcomes that are identified, whether at individual or service level, are a product of the activity under scrutiny? Is it partnership working that has produced the observed outcomes or could they have occurred as the result of other extraneous activity?

Dowling et al (2004) discussed in detail the interpretations of success, either implicit or explicit, which are applied to partnership working. He found that the majority of studies focussed on the *process* of partnership working, for example the extent of common agreement as to the purpose of the partnership, the levels of trust and reciprocity, and the perceived benefits for staff. Few had looked in detail at the impact of partnership working

on those at the receiving end, whether it made a difference to service user and carer *outcomes*. A recent update from Cameron et al (2012, p16) observes that ‘the voice of service users and carers remains largely absent’ (p16). This is a critical distinction and has to be central to any discussion of the effectiveness of partnership working.

### **Study aims**

This paper describes a project that sought to address this core gap in the evidence base, by exploring the relationship between outcomes for people using services and key features of partnership working. Specifically the project addressed the following research objectives:

- determine the outcomes important to people using services
- assess the extent to which health and social care partnerships deliver the outcomes that service users value
- determine the features of partnership working that lead to the outcomes that service users value
- refine the initial interview schedule into a generic user-defined service effectiveness tool.

### **Study design**

It was not possible to generate one robust theory that could be examined in more detail through a theory of change approach to evaluation. An exploratory, qualitative approach was therefore taken to the research that included extensive development and piloting phases. The research was undertaken in close partnership with three user led organisations, SURE (Service User Research Enterprise), Central England People First, and Older People



Researching Social Issues (OPRSI) (Miller et al, 2006). Approval from COREC, the Central Office of Research Ethics Committees, was obtained for this project at an early stage. The research team also had to gain approval from the Research and Development office of every trust involved in the project.

The project was carried out between 2004 and 2006 and involved three main stages of research:

1. validating a framework of outcomes important to people using services delivered in partnership between health and social care and an interview tool to explore these outcomes in the context of partnership working;
2. mapping partnership working across the UK to identify 15 services and to distinguish key features of partnership working in these sites;
3. semi-structured, qualitative interviews with 230 people using services delivered in partnership between health and social care, including 63 older people, 87 people with an intellectual disability and 80 people using mental health services.

### **Framework development**

A key concern of the study was to build on existing work exploring the outcomes important to service users, in particular that developed by the Social Policy Research Unit (SPRU) at the University of York under an earlier DH research initiative, the OSCA programme. Over a period of five years the SPRU project had explored the outcomes sought by older people (Qureshi, 2001) and subsequently people with disabilities (Harris et al, 2005), and had promoted the adoption of evaluation based on these outcomes in routine practice (Nicholas et al, 2003; Glendinning et al, 2006). This work characterised three types of outcomes:

maintenance, change and process. The first focuses on the quality of life outcomes that individuals are seeking in their daily lives, for example meaningful activity; the second on outcomes during a period of change, for example regaining mobility following a hospital episode; and the third on the experience of the process of support provision, including the quality of the interaction with individual staff.

The Glasgow-based team held a series of three focus groups with service users to validate these outcomes and to find out whether any revisions were required. These were partly or wholly facilitated by organisations with research and/or advocacy expertise. The focus groups were with older people (members of Fife User Group), adults with mental health problems (Highland Users Group) and adults with intellectual disabilities (Central England People First). The focus groups were structured around three key questions, designed to represent the three types of outcome identified by SPRU: What is important to you in life? What can services do for you? And what do good services look like?

Data from the focus groups was analysed thematically and confirmed the validity of the SPRU outcomes framework. Service user researchers and focus group participants questioned the inclusion of the outcome of being personally clean and comfortable. Many individuals who had no experience of physical disability thought that being asked about this could cause offence. Two new quality of life outcomes emerged as being important, living where you want and dealing with stigma and discrimination. The responsiveness of services, or the experience of being responded to also emerged. The research team worked with the service user research partners to distil the outcomes into a core framework of 15 outcomes reflecting those most important to all service user groups, and to reframe them in terms

understandable to both the research interviewers and service users. These are summarised in Table 1. Having determined the outcomes framework which would underpin the interview tool, a draft schedule was developed with the service user research partners. It included questions addressing each of the key outcomes identified by service users in respect of quality of life and service delivery, while change outcomes were addressed through an open question about the differences services made to individuals' lives. Initial interviews were completed in three sites in Scotland, resulting in further modification to the schedule.

INSERT TABLE ONE ABOUT HERE

### **Mapping partnerships**

A key challenge for the project was identifying examples of partnership working that could serve as field sites for the evaluation. This was done through review of the Health Act Flexibilities Register for England, review of NHS and local authority websites, and through contact with key informants in the fields of ageing, intellectual disability and mental health. Significant efforts were invested in the early stages to try to develop a typology of partnerships, based on a range of features of partnership at strategic and operational levels. Given the state of flux in most partnership areas, and the degree of variation between them, the focus turned towards recruiting specific services provided in partnership, as opposed to higher level strategic partnerships. It was also felt that this would increase the likelihood of

people using services being able to reflect and comment on partnership arrangements. The following selection criteria were then applied:

- the service operating as a partnership in the current form for at least a year
- involving health and social care as lead organisations
- organisations involved seeking to 'mainstream' partnership working
- sufficient numbers of service users currently or recently using the service to enable twenty interviewees to be identified
- location accessible to the user research teams.

A total of fifteen partnerships were identified, three in Scotland and twelve in England. The sample included a mix of urban/rural sites, varied socio-economic backgrounds and sites more likely to include people from black and minority ethnic populations. Information about each of the partnerships was gathered from interviews with key informants in the sites, from websites and from local policy documents. This process, together with the literature, identified a number of indices of partnership working (Table 2), with information systematically gathered in each partnership site.

INSERT TABLE 2 ABOUT HERE

### **Interviews with service users**

The project sought to interview 20 people using services in each site, with access negotiated through a gatekeeper in the service. In keeping with the qualitative design, a diverse, as opposed to representative sample was sought in terms of age, gender, ethnicity, living circumstances and need. The research team also emphasised their commitment to engaging

with people with mixed experiences of the service and with communication difficulties to obtain a balanced picture. Where possible interviews were carried out with the service user themselves; for service users with major cognitive impairments interviews were carried out with unpaid or occasionally paid carers. Some interviews with people with intellectual disabilities were carried out in the presence of a support worker. All respondents were offered £20 as a 'thank you' for taking part in the research (they were not aware of this at the recruitment stage). Informed consent was negotiated with all interviewees and permission was sought to make an audio recording of the interview. Interviews generally lasted between 20 and 40 minutes, although they tended to be longer with older service users. The recorded material was transcribed and entered into NVivo for management and coding, along with the information gathered from each service from the mapping exercise.

## **Analysis**

The interview data were analysed in stages by four members of the academic team and service user researchers from OPRSI (with academic support) and SURE. In the first instance three of the academic team separately coded and cross-coded a sample of transcripts from the pilot interviews to develop a coding scheme. This scheme was then used by the whole team to code all interviews, with a limited number of new codes being added in response to new themes emerging from the data. Following coding, the data were subject to a three-stage analysis process. Initially data were analysed by fieldwork site, and a summary report for each site produced. Data were then analysed across services and within client groups to identify themes relevant to particular groups, linked to the features of services and partnership captured by the research team and discussed by participants. Finally the team

analysed the data across all client groups looking for commonalities and divergence in terms of the kinds of outcomes achieved for individuals and the relationship to features of service and partnership in each site. These themes were then explored further in the data, focussing in particular on the reports of individuals who were able to reflect on the organisation of services and how this impacted on their lives.

### **Personal Outcomes**

Analysis of the interview data wholeheartedly reinforced the salience of the outcomes framework in table 1. The high-level nature of these outcomes enabled the capture of a range of experiences under each outcome. For example when talking about safety, service users raised a wide range of issues including fear of falling, stigma, abuse, road safety and safety in the home to self-harm. These differences reflected the diverse perspectives, circumstances and aspirations of the people interviewed. Despite this diversity it was possible to discern some important trends within and between client groups. A future article will address the differences between groups.

It was important to respondents from all groups to have meaningful activity in their lives and to have contact with other people. Interviewees from all three groups indicated that how they were treated by staff was at least as important as what services achieved with regard to quality of life and change outcomes.

Differences between groups were more evident in respect of the nature of contact with other people. In particular, there was a stronger emphasis by people using mental health services on social contact with other service users. Although there were exceptions, many

individuals using mental health services identified that they enjoyed opportunities to mix with people who they believed would be less likely to judge or stigmatise them. For people with intellectual disabilities, there was more emphasis on relationships with trusted members of staff. In contrast to the other two groups, older people tended not to express preferences over whom they wanted to have contact with. Of the three groups, older service users more frequently experienced significant social isolation. Change outcomes were more generally relevant to older service users, reflecting the fact that most of the older people interviewed had come into contact with services following an acute health episode. Change outcomes were also emphasised by some users of mental health services. They were less evident in interviews with people with intellectual disabilities, who talked more about quality of life (Miller et al, 2008).

A clear finding was that the people interviewed in this project were generally supported to achieve good outcomes. This in part reflects the overall quality of the services included in this project, all selected on the basis that they were stable partnerships, including integrated working at service delivery level, and not experiencing any specific difficulties or transitions. Where there was more divergence was in relation to quality of life outcomes. Reasons for these divergences are examined in more detail below.

### **Features of services delivered in partnership contributing to good outcomes**

Analysis of the detailed accounts enables the identification of generic features of services which are essential to supporting partnerships to deliver good outcomes to users: continuity of staff and sufficient staff; good resources; and the availability of preventative and long-term services, enabling fluid support matched to the needs of the user. Service users and

carers also identified limitations and barriers to effective services. Often the converse of the features identified above, these particularly included staffing levels and lack of continuity of staffing; limited resources; access to transport – especially in rural areas; and time-limited services.

TABLE 3 ABOUT HERE

Table 3 looks in more detail at what could be discerned from the data about the relationships between specific outcomes and features of services (column three) and features of partnership (column four). Looking across the partnerships, this allows for the identification of four key operational features.

### ***Co-location***

Most of the services where we conducted interviews involved the location of health and social services staff in one building. Co-location was viewed as important because it enabled service users to access different staff from one central place, and it facilitated improved communication between staff about their needs. Perhaps most importantly, given the emphasis placed by users and carers on this outcome, there were indications that the responsiveness of services was enhanced by co-location. In other words, process outcomes, or how the service was delivered, were facilitated by co-location.

Service users usually had one phone number they could use to access various members of staff who might be involved in delivering their service. This single point of contact, facilitated by co-located partnerships, was appreciated by users and carers.



I think it's a good idea because I don't have to phone different agencies. I think - one phone call to that number up there, and I will get whoever I need... I've got one number and that's good. I'm pleased. (service user, East Renfrew)

Service users sometimes referred to difficulties they had previously had accessing support. There were comments like this from each user group.

I was shunted from pillar to post. I felt like a carrier pigeon to be honest. (service user, Goldenhill)

### ***Multidisciplinary team***

Users and carers valued services that simultaneously met their health and social needs. The meeting of these needs is not necessarily dependent on partnership, but the availability of multidisciplinary staff in one setting did seem to successfully deliver health and social care outcomes for users. All of the partnerships aimed to provide meaningful activity for users, improve their social contact and enhance their general wellbeing. The availability of both health and social care was valued by users in achieving both change outcomes and quality of life outcomes.

I think it's a nice thing, you feel as if you're in a little net and they're all working together to make sure that you are fine (service user, Knowsley)

Some of the partnerships for older people in particular were largely focused on change outcomes. Many of the older users we spoke to had entered services following a health crisis. Some of the changes included assistance to recover confidence and skills after a stroke or fall, and modifying the environment to improve mobility. Such interventions clearly have the potential to support service users in improving wellbeing, as well as in

achieving the goal of independence. However, the importance of social and emotional care was also emphasised by users.

The other thing is that they have two [goals] at the ARC. One is the caring of the person and the other one is the looking into the person's disabilities. (service user, Blackpool)

One example of where multidisciplinary input added value was that partnerships were particularly successful at meeting the health needs of people with intellectual disabilities, an issue which has proved problematic for generic services. It was notable that when people with intellectual disabilities talked about health, many users spoke in holistic terms about how they were supported to stay healthy, demonstrating knowledge of the relationship between health, exercise and diet.

The mental health service users who were most satisfied with the support they received were accessing holistic support. Services not only supported them with medication to keep them well and out of hospital, but also offered emotional support and the opportunity to engage in activities, including those designed to develop practical and employment skills. These services also provided support to service users with housing issues and benefits.

If your health suffers, your social suffers, and if your social suffers, your health suffers. So it's better to be all working together if you know what I mean? (service user. Goldenhill)

### ***Specialist partnerships***

The concept of specialist partnership was the first of two partnership features which emerged through interviews. Most partnerships were specialist in the sense that they were established to support a specific user group and this meant that staff understood the needs of that particular group. Users identified that staff in partnerships were less likely to treat them in a discriminatory manner, often contrasting their experience of the partnership with experiences of the acute sector in particular. Several individuals made comments to the effect that staff were able to 'see beyond labels.' This relates to a process outcome, being treated with respect. Users of mental health partnerships valued not feeling stigmatised. One user contrasted the treatment she received from the team in Lewisham with the dismissive attitude of staff in a general hospital setting. Service users also spoke of services as being a safe haven, free from stigma.

I don't know how to put this. Just the general treatment. You're treated, not on the same level, but at the same time you're spoke to as a person, as a human and not as a diagnosis. (service user, Camden)

Several older individuals valued being listened to, rather than being 'patronised.'

There's an awful tendency in social work with old people, many social workers approach the over-65s as if they newly appeared at the age of 65 and they have no knowledge, no experience and they have to be patted on the head for them to talk, what to do. This group talk to you as adults, listen to you and they're obviously working together, it's a service, it's not a patronising. (service user, East Renfrew)

### ***Extended partnership***

Extended partnership was the second of two features of partnership working which emerged through interviews, and had not been originally included in our indices. Health and social care partnerships which extended into other sectors, including housing, benefits advisors and/or the voluntary sector, improved outcomes for users. This broader partnership working improved communication with other agencies to the benefit of service users, and often increased the options and opportunities available to users.

Oh yes. This is like a stepping stone. They help you contact other services and let you know, enlighten you to other services that are available. (service user, Camden)

There were also examples from all three users groups where individuals identified staff taking an advocacy role on their behalf with other mainstream services.

## **Discussion**

In the context of continued policy emphasis on integration between health and social care, and a system increasingly concerned to embed a focus on outcomes into policy and practice, the development of a robust and accessible framework summarising the outcomes important to people using services is an important output of this project. Indeed since the completion of this project in 2006, two of the authors have been working with the Joint Improvement Team of the Scottish Government and have used this framework as the basis for a significant programme of work, the Talking Points Personal Outcomes Approach, which has had demonstrable policy and practice impact (Cook and Miller, 2012).

The findings of the research described in this paper also make a contribution to the debate around partnership working. By identifying key features of partnership working that make a difference to people using services, this project provides evidence for those seeking to navigate the changes required. A more recent review of the evidence on partnership working was undertaken by the first author during 2011. This review suggested a number of key dimensions to effective service delivery across health and social care, including the importance of culture; the role of leadership; the place of local history and context; the need to start with a focus on those who access support; and the role of integrated health and social care teams (Petch, 2011). Although these dimensions do not correspond exactly with the features of partnership identified by this research, there is a commonality in the general emphasis on the need for integrated activity at the frontline.

It has more recently been argued that the lack of evidence of partnership may be largely due to the complexity of the environment (Glasby and Dickinson, 2009). In the context of

partnership working, the traditional experimental method is often not feasible. It may be necessary therefore to rely on what would be traditionally termed 'most likely' explanations, or in more contemporary terminology 'theories of change', in order to relate particular activity to outcome (Sullivan et al, 2002; Dickinson, 2006). It has been argued that the onus to specify such theories at the outset should assist in teasing out not only causal chains but interactions across the whole system. Health and social care systems are complex, open systems and what is being sought is a flexible approach that can embrace this complexity yet still say something of value (Barnes et al, 2003). Contribution analysis (Mayne, 1999) is currently being considered as an approach related to theory of change in relation to Talking Points in Scotland.

#### Key limitations of this study

- Due to the geographical spread of research sites, and the need to ensure ease of access for service user researchers, this study relied on service providers to recruit interviewees, which may have resulted in bias in selection.
- Given the definitional and methodological issues associated with researching partnership working, significant efforts to develop a typology of partnerships would have been better employed in developing a theory of change on which to base the research. This might have resulted in more robust findings about the effectiveness of partnership working per se in relation to outcomes.
- Staff views on partnership working in their locality could have usefully enhanced the research project. Staff perspectives on perceived effects on aspects of partnership such as cultural integration and improved communication could have contributed to a fuller picture, particularly if related to a theory of change.

- Of the four features of partnership identified, the concept of specialist partnership was the most tentative and least specific to partnership working.

## **Conclusion**

The features of partnership identified by service users highlight the importance of effective integration at the frontline of services, and partnerships which extend to a range of local services and resources. These are associated with holistic outcomes and improved process outcomes, including a feeling of being responded to. It is critical that the renewed emphasis on service integration between health and social care should retain a focus on improving these outcomes important to the individuals accessing support.

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## **LIST OF TABLES**

**Table One: Outcomes underpinning the interview schedule**

**Table Two: Indices of partnership working**

**Table Three: Features of services and partnerships promoting the outcomes users want**

**Table One: Outcomes underpinning the interview schedule**

| <b>Quality of life</b>              | <b>Process</b>           | <b>Change</b>                  |
|-------------------------------------|--------------------------|--------------------------------|
| Feeling safe                        | Listened to              | Improved confidence and skills |
| Having things to do                 | Choice                   | Improving mobility             |
| Seeing people                       | Treated as an individual | Reduced symptoms               |
| Staying as well as you can be       | Reliability              |                                |
| Living life as you want             | Responsiveness           |                                |
| Living where you want               |                          |                                |
| Dealing with stigma (mental health) |                          |                                |

**Table Two Indices of Partnership Working**

|  |
|--|
| Single shared assessment processes   |
| Single point of entry / contact with the service for users   |
| Regular and routine contact between professionals fulfilling different roles in relation to needs of individuals |
| Single consultation process with users   |
| Shared mission statement / objectives  |
| Joint training for staff   |
| Shared information systems   |
| Co-location of staff   |
| Joint management   |
| Joint planning and commissioning   |
| Pooled or aligned budgets  |
| Partnership agreement in place   |
| Accountable to health and local authority  |
| Reported use of Health Act Flexibilities   |

|                                 | <b>Experience of service users</b>   | <b>Features of service promoting that outcome</b>  | <b>Features of partnership enabling that outcome</b>  |
|---------------------------------|--|--|---|
| <b>Quality of life outcomes</b> |  |  |   |
| Feeling safe                    | Physical safety – feeling safe in neighbourhood, getting out and about, managing tasks of daily living, avoiding falls (for older people)<br>Emotional safety – knowing help is on hand, being safe from intimidation, abuse and stigma                        | Staff working together<br>Regular contact with stable and trusted staff group<br>Easy access to responsive services, in particular out of hours, enhanced by single point of contact   | Multidisciplinary team working together to promote social and emotional wellbeing and physical mental health<br>Specialist services treating individuals in a non-discriminatory manner<br>Co-location improving communication and responsiveness |
| Having things to do             | Opportunities for meaningful activity and employment during the day and evening promoted self-esteem, wellbeing and mental health, and supported people to live a 'normal' life  | Good resource base, offering options for activities<br>Self-advocacy groups an additional source of meaningful activity for users  | Extended partnership with voluntary sector, local employers and employment agencies providing meaningful activity, particularly opportunities to engage in mainstream activities  |
| Contact with other people       | Relationships with staff and other users vital for combating isolation for those most excluded. Others needed support to sustain relationships with family and friends.<br>Relationships between users and wider community often more challenging to establish | Continuity of staffing helped promote supportive relationships with staff<br>Opportunities for informal contact with other users supported by group activity, drop-in and sensitive planning of service use eg co-ordinating respite schedules | Extended partnerships also create opportunities to meet people and form relationships   |
| Staying as well as you can be   | Users wanted support with all aspects of wellbeing, often emphasising links between quality of life and physical and mental health<br>Support from regular staff was valued in accessing mainstream and specialist services                                    | A focus on the various needs of the individual<br>Facilitating access to mainstream and specialist health services<br>Healthy living groups valued   | Multidisciplinary team working together to promote social and emotional wellbeing and physical and mental health<br>Co-location enabling users to access support from diverse professionals quickly   |

| Process outcomes                        |  |  |   |
|---|--|--|---|
| Being listened to                       | Important to users in order to have a say over their day-to-day life and service use<br>Very important to users who were fearful or distressed   | Stability of staffing; adequate staff<br>Good relationships helped communication, sometimes supported by key worker systems<br>Opportunity for collective user voice   | Co-location can assist with communication   |
| Feeling valued and treated with respect | Key issues for users were being treated as an adult, and an individual, and not being stereotyped. There were strong links with being listened to.   | Consistency of staffing; adequate staff numbers. Staff with specialist knowledge of the user group demonstrated understanding of needs, and responded appropriately  | Specialist services with shared knowledge and experience of the user group leading to non-discriminatory treatment  |
| Having choices                          | Users wanted choice and control over where they lived and how they lived their life, and particularly over their daily routine. Only one carer reported wanting a choice of service provider | Choice over daily routines was largely determined by the core service. Person centred planning enabled user to have a say in how they lived their life. Having sufficient staff was important in implementing these plans. Choice over other aspects of life could be enhanced by links with other services. | Multidisciplinary team sharing information about individual circumstances. Communication assisted by co-location. Extended partnership increased available options eg activities, accessing appropriate accommodation |
| Having people to rely on                | Users and carers wanted the security of knowing that staff would adhere to arrangements, and that if unavoidable delays occurred, that someone would contact them                            | Consistency of staffing and adequate staff numbers. Good communication   | Co-location can assist with communication   |
| Knowing someone will respond            | Knowing services would respond at times of need was very important; easy access to services was highly valued. Out of hours support was viewed as  | Single point of contact<br>Good communication between staff and agencies. Evening and weekend support.<br>Good relationships between service user  | Co-location   |



|                                 |   |  |  |
|---------------------------------|---|--|--|
|                                 | vital in an emergency and its availability was associated with feeling safe   | and staff  |  |
| <b>Change outcomes</b>          |   |  |  |
| Improving skills and confidence | Following episodes of ill-health, users (especially older people) wanted services to support restoring confidence and skills. People also wanted to remain independent and stay out of hospital | Staff working as a team to meet various needs<br>Good relationships with staff and opportunities for interaction between service users | Multidisciplinary team working together to promote social and emotional wellbeing and physical and mental health. Informal partnership providing opportunities for activity and social contact |
| Improving mobility              | Following episodes of ill health, users (especially older people) wanted services to improve mobility where possible, and/or provide adaptations where required                                 | Staff working as a team to meet mobility requirements  | Multidisciplinary team   |
| Reducing symptoms               | Service users with serious mental health and/or physical health problems wanted support to alleviate symptoms   | Staff working together to alleviate pain, reduce symptoms  | Multidisciplinary team   |

**Table Three: Features of services and partnerships promoting the outcomes users want**